STAFFING PLAN: CHILD CARE CENTERS State of Michigan Department of Human Services

Office of Children and Adult Licensing

List information	for all staff	and volunteers	in the program.
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Facility Name:	License Number:														
Signature:				Title:						Date:					
_	Designee)						_								
				Work Schedule		Da	Date of		Date of Completion			Date of Staff Screening			
Name	Name	Position	Date of Hire	Days	Times	TB Test	Physical	CF Infant		First Aid	Blood- Borne Path	CPS	Fingerprint/ ICHAT*	Signed Abuse/ Neglect Statement	
*Electronic finge	rprint clearance is required by p	rogram director	and licensee on	ly. ICHAT red	quired for all	other cent	er staff.		•				ı		
Authority: Completion: Consequence:	on: Mandatory Failure to provide requested information may result in license denial agé, national origin, color, height, weight, marital status, political béliefs or disability. If you need help with readin writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a Diffice in your area.									sex, religion, with reading, vn to a DHS					
You may copy this form if you need additional sheets.															